DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 04 — 14

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: Sept. 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 Part F

7. FEDERAL BUDGET IMPACT
a. FFY 2005 $ 7.2 million
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Supp4, pp 1-2 of 2.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B, Supp4, p 1.

10. SUBJECT OF AMENDMENT: Rate Increase for OB/GYN Fees

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: Patrick W. Finnerty

14. TITLE: Director

15. DATE SUBMITTED:

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulation Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 8/31/04

18. DATE APPROVED: MAR 17 2005

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 9/1/04

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE: ARA/DMCH

23. REMARKS

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE
ESTABLISHMENT OF RATE PER VISIT

The State Agency Fee Schedule

Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of Home Health services (see Supplement 3), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS). The RBRVS fees shall be the same for both public and private providers.

A. For those services or procedures which are included in the RBRVS published by the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

B. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. DMAS shall adjust CMS's CFs by an additional factor so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. . DMAS shall calculate a separate additional factor for (1) Obstetrical/Gynecological procedures (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual) and for (2) all other procedures set through the RBRVS process combined. DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the additional factors required above shall be accomplished by means of the following calculation:

1. The estimated amount of DMAS expenditures if DMAS were to use Medicare's RVUs and CFs without modification, is equal to the sum, across all relevant procedure codes, of the RVU value published by the CMS, multiplied by the applicable conversion factor published by the CMS, multiplied by the number of occurrences of the procedure code in DMAS patient claims in the most recent period of time (at least six months).

2. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new CMS RVUs and CFs is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of occurrences of the procedure codes in DMAS patient claims in the period of time used in subdivision 1 of this subsection.

3. The relevant additional factor is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision 2 of this subsection) to the expenditure estimate based on unmodified CMS values in subdivision 1 of this subsection.

C. For those services or procedures for which there are no established RVUs DMAS shall

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approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service and/or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

D. Fees shall not vary by geographic locality.

E. The RBRVS-based fees shall be phased in over three years. During the first 12 months of implementation, fees shall be based 1/3 on RBRVS-based fees and 2/3 on previously existing fees. During the second 12 months of implementation, fees shall be based 2/3 on RBRVS-based fees and 1/3 on previously existing fees. Thereafter, fees shall be based entirely on RBRVS-based fees.

F. Beginning with dates of service on or after September 1, 2004, fees calculated through Sections A-E above for CPT codes 99281, 99282, 99283, 99284, and 99285, shall be increased by two percent. This increase shall not be considered in the determination of the "additional factor" described in Section B above. These CPT codes shall be as published by the American Medical Association in its Current Procedural Terminology (2004 edition), as may be amended from time to time.

G. Effective for dates of service on or after September 1, 2004, fees for Obstetrical/Gynecological procedures (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual) shall be increased by 34 percent relative to the fees in effect on July 1, 2004. This 34 percent increase shall be a one-time increase, but shall be included in subsequent calculations of the relevant "additional factor" described in Section B above.

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